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No. 03-1202

In the Supreme Court of the United States

HEWLETT-PACKARD COMPANY EMPLOYEE BENEFITS ORGANIZATION INCOME PROTECTION PLAN, PETITIONER

v.

DONALD JEBIAN

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), this Court held that the denial of employee benefits by an administrator under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, was entitled to deference when the plan conferred discretion on the administrator to determine eligibility for benefits. Under 29 C.F.R. 2560.503-1(h)(4) (2000), a claim for benefits is "deemed denied on review," thereby enabling the claimant to bring suit, if the specified fiduciary (here, the claims administrator) failed to review an initial decision to deny benefits within a certain period. The question presented is as follows:

Whether an administrator's decision to deny benefits on appeal is entitled to deference when the claim for benefits had been "deemed denied on review" under 29 C.F.R. 2560.503-1(h)(4) (2000).

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This brief is filed in response to the Court's invitation to the Acting Solicitor General to express the views of the United States. The position of the United States is that further review of this case is not warranted.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, regulates employee welfare and pension benefit plans, including disability plans. 29 U.S.C. 1001(a), 1002(1). ERISA requires every covered employee benefit plan to provide a two-stage process for the evaluation of employees' benefit claims. At the first stage, if the plan denies the claim, it must "provide adequate notice in writing * * *, setting forth the specific reasons for such denial." 29 U.S.C. 1133(1). At the second stage, the plan must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by

the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133(2). A claimant may file suit to recover benefits due under the terms of the plan. 29 U.S.C. 1132(a)(1)(B). Courts have uniformly held that the claimant must exhaust his administrative remedies with the plan before filing suit. See, *e.g.*, *Fallick* v. *Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 & n.4 (6th Cir. 1998) (listing cases).

Pursuant to statutory mandate, see 29 U.S.C. 1133, the Secretary of Labor has promulgated regulations governing the two-stage claims process. Under the prior version of the regulations, which governs this case, a plan was required to notify a claimant of its initial decision within a reasonable period of time, not to exceed 90 days absent special circumstances (and 180 days in any event) from the filing of the claim. 29 C.F.R. 2560.503-1(e)(1) and (3) (2000). If notice of the denial was not provided within that period, the claim was "deemed denied," and the claimant was permitted to proceed to the appeal stage. 29 C.F.R. 2560.503-1(e)(2) (2000). At that stage, the specified fiduciary was required to make a decision within 60 days, unless special circumstances required an extension of time for processing, but in that event no later than 120 days after receipt of the request for review. 29 C.F.R. 2560.503-1(h)(1)(i) (2000). If an extension of time was necessary because of special circumstances, the administrator was required to furnish written notice to the beneficiary prior to commencement of the extension. 29 C.F.R. 2560.503-1(h)(2) (2000). If the fiduciary failed to furnish its decision to the claimant within the period allowed, the claim was "deemed denied on review." 29 C.F.R. 2560.503-1(h)(4) (2000).[1]

2. Petitioner is an ERISA-covered plan with an independent claims administrator. Pet. App. 3a. The plan contained procedural requirements, including "deemed denied"

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[1] As explained below, the Secretary promulgated new regulations in 2000 that delete the "deemed denied" provision and impose new and more flexible deadlines. See pp. 16-20, *infra*.

provisions, that were consistent with the regulations then in effect. *Id.* at 136a-142a. Although the plan did not give the claims administrator discretion in making initial claims decisions, *id.* at 136a-139a, it did confer discretion on the administrator in making decisions on appeal, including "the authority to determine eligibility for benefits and to construe the terms of the Plan," *id.* at 139a.

Respondent was a participant in the plan. In February 1998, respondent applied for long-term disability benefits because of back and shoulder pain. Pet. App. 2a-4a. On August 3, 1998, the claims administrator denied the application. *Id.* at 4a. On August 18, 1998, respondent informed the claims administrator in writing of his intent to appeal, and he formally submitted his appeal (together with new medical evidence) on November 11, 1998. *Id.* at 34a-35a. On March 15, 1999, some 119 days after receiving the formal appeal, the claims administrator wrote to respondent, addressing respondent's objections to the initial decision but leaving the appeal open to consider further medical evidence. *Id.* at 5a. On June 11, 1999, the claims administrator again wrote to respondent, indicating that the appeal remained open pending the receipt of additional documentation. *Id.* at 6a. On September 29, 1999, respondent filed suit in federal district court, seeking to recover benefits under 29 U.S.C. 1132(a)(1)(B). Pet. App. 7a. On November 5, 1999, the claims administrator notified respondent that his appeal had been denied, and provided a detailed explanation for the denial. *Id.* at 7a, 36a.

3. Both parties then moved for summary judgment in the district court. Petitioner contended that the claims administrator's decision to deny benefits on review was entitled to deference under *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), in which this Court held that an administrator's decision to deny benefits was entitled to deference when the plan conferred discretion on the administrator to determine benefit eligibility. Respondent contended that, once his

administrative appeal was "deemed denied" because the administrator had failed to issue a timely decision, the administrator was divested of any discretion in deciding the appeal, the denial was thus not entitled to deference, and the suit for benefits should be decided *de novo* by the district court. The district court agreed with petitioner on the standard of review and granted summary judgment to petitioner on the merits. Pet. App. 31a-41a, 44a-46a.

4. a. The court of appeals reversed and remanded. Pet. App. 1a-30a. The court held that, where the applicable plan and regulatory language provide that a claim is "deemed denied" on review after the expiration of a given time period, "there is no opportunity for the exercise of discretion and the denial is usually to be reviewed *de novo*." *Id.* at 7a. According to the court, "[w]hile deference may be due to a plan administrator that is engaged in a good faith attempt to comply with its deadlines when they lapse, this is not such a case." *Ibid.* The court noted that the claims administrator failed to provide written notice that additional time was required within the initial 60-day period for review; failed to provide any form of written notice until one day before the expiration of the extended 120-day period; and failed to specify, in that written notice, what additional information was required. *Id* at 8a.

In concluding that the appropriate standard of review in this case is *de novo*, the court of appeals relied on this Court's decision in *Firestone Tire*, which held that an administrator's decision was entitled to deference only when the plan conferred discretion on the administrator. Pet. App. 9a. According to the court, "[w]e are just as bound by the Plan language deeming denial in the event that time limits are exceeded as we are bound by the Plan language that grants discretion to the Plan administrator." *Ibid.* The court thus concluded that "[d]ecisions made outside the boundaries of conferred discretion are not exercises of discretion, the substance of the deci-

sions notwithstanding." *Ibid.* The court reasoned that such a rule is consistent with the general rule applicable to judicial review of federal agency decisions, *id.* at 9a-10a, and with the rule that deference is not owed to a decision to deny benefits under an ERISA plan when the decision was made by an entity other than the one authorized to do so in the plan, *id.* at 10a.

Finally, the court of appeals reiterated that, "[a]bsent unusual circumstances, an administrator engaged in a genuine, productive, ongoing dialogue that substantially complies with a plan's and the regulations' timelines should remain entitled to whatever discretion the plan documentation gives it." Pet. App. 15a. But because the claims administrator here had failed to engage in such an "ongoing, good faith exchange," the court concluded, *de novo* review was appropriate. *Ibid.* After reviewing the evidence, the court found a genuine issue of fact concerning whether respondent is disabled, and it remanded the case to the district court to decide that issue *de novo*. *Id.* at 16a-20a.[2]

b. Judge Tashima dissented. Pet. App. 21a-30a. In his view, *de novo* review was not required simply because of a procedural irregularity in the administrator's handling of a claim. *Id.* at 21a-25a. Judge Tashima also stated that, even under the majority's rule, *de novo* review was not appropriate in this case because "[t]he facts indicate * * * that [the claims administrator] was attempting to engage in a meaningful exchange of information with [respondent]." *Id.* at 29a.

DISCUSSION

The petition for a writ of certiorari should be denied. The court of appeals' decision to conduct *de novo* review of respon-

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[2] The court of appeals held that, in applying a *de novo* standard of review, the district court could consider evidence outside the administrative record. Pet. App. 19a. Petitioner does not expressly challenge that holding in the petition.

dent's benefits claim in the particular circumstances of this case was reasonable. Although there is some divergence among circuits on the question whether the decision of an administrator with discretionary authority is entitled to deference when the claim for benefits was "deemed denied on review" under the Secretary's prior regulations, the cases implicated in that circuit conflict can largely be reconciled. Equally important, since the events at issue in this case, the Secretary of Labor has promulgated new regulations that, *inter alia*, eliminate the regulatory "deemed denied" directive. Because the analysis may differ under the new regulations, this case presents a question of limited and diminishing importance. Accordingly, further review is not warranted.

A. Although The Courts of Appeals Have Taken Varied Approaches To The Standard Of Judicial Review For "Deemed Denied" Claims, There Is Not A Clear And Current Split Warranting This Court's Review.

1. This Court has twice addressed the standard of judicial review in suits for ERISA benefits under 29 U.S.C. 1132(a)(1)(B). In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101 (1989), the Court stated the general rule that a denial of benefits under ERISA is "to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. The Court began by noting that Section 1132(a)(1)(B) does not prescribe a particular standard of review. 489 U.S. at 109. The Court therefore determined that the appropriate standard of review should be "guided by principles of trust law," under which *de novo* review is the default rule. *Id.* at 111-112. However, the Court reasoned that a deferential standard of review is appropriate when "a trustee exercises discretionary powers." *Id.* at 111. Applying that rule in the ERISA context, the Court concluded that the denial of benefits should be

subject to deferential review when the benefit plan confers discretion on the administrator. *Id.* at 115.

More recently, in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), the Court held that ERISA did not preempt a state statute that required a health maintenance organization furnishing health benefits to an ERISA-covered plan to provide a medical service if a reviewing physician concluded that the service was medically necessary. *Id.* at 386-387. In so concluding, the Court briefly revisited its discussion in *Firestone Tire* of the appropriate standard of review. After reiterating the rule of *Firestone Tire*, *id.* at 384, the Court again noted that nothing in ERISA itself expressly speaks to the standard of judicial review for benefit claims, and that there is no requirement derived from ERISA that "even indirectly" compels a lenient standard of review, *id.* at 385.

Taken together, *Firestone Tire* and *Rush Prudential* establish the following principles: (1) nothing in ERISA entitles plans to deferential review in all cases, *Rush Prudential*, 536 U.S. at 385; (2) *de novo* review of benefit claims is the "general or default rule" under ordinary principles of trust law, *id.* at 385-387; and (3) deferential review is appropriate when an administrator "exercises discretionary powers," *Firestone Tire*, 489 U.S. at 111.[3]

2. Petitioner does not contend that the decision below conflicts with any decision of this Court. Instead, petitioner

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[3] In *Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134 (1985), the Court held that a claimant could not recover extracontractual damages from a plan fiduciary on account of the fiduciary's untimely processing of the underlying claim. *Id.* at 148. Although the Court did not address the standard of judicial review applicable in cases in which a claim was "deemed denied on review" under the version of the claims regulations then in effect, the Court did note that the regulations "enable[d] a claimant to bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits." *Id.* at 144.

contends (Pet. 11-17; Reply Br. 4-8) that there is a circuit conflict warranting this Court's intervention on the appropriate standard of review in cases in which the underlying claim for benefits was "deemed denied on review" under the Secretary's prior regulations. Petitioner overstates the extent of divergence in the courts of appeals.

a. A number of circuits that have addressed the issue, including the Ninth Circuit in the decision below, have held that an administrator's decision in a "deemed denied" case may be entitled to deference depending on the extent to which the administrator complied with ERISA's procedural requirements. In a decision followed by the Ninth Circuit in this case (Pet. App. 14a-15a), the Tenth Circuit held that, "when substantial violations of ERISA deadlines result in the claim's being automatically deemed denied on review, the district court must review the denial *de novo*." *Gilbertson* v. *Allied Signal, Inc.*, 328 F.3d 625, 631 (2003). On the other hand, when there was "an ongoing, good faith exchange of information between the administrator and the claimant," "inconsequential violations of the deadlines or other procedural irregularities would not entitle the claimant to *de novo* review." *Id.* at 635. The Tenth Circuit ultimately concluded that the administrator in that case was not in substantial compliance because it had failed to participate in a "meaningful dialogue" with the claimant, and in fact had never issued a decision on appeal. *Id.* at 636.

By contrast, in a subsequent decision, the Tenth Circuit held that a claims administrator was in substantial compliance, and its decision was entitled to deference on judicial review, when the claimant had presented no relevant new evidence on appeal and the administrator had denied the appeal only 27 days late. *Finley* v. *Hewlett-Packard Co. Employee Benefits Org. Income Protection Plan*, 379 F.3d 1168, 1172, 1174 (2004). Indeed, the Ninth Circuit itself—relying both on the Tenth Circuit's decision in *Gilbertson* and on its

own decision in the instant case—has since applied a deferential standard of review in a case in which the administrator missed the regulatory deadline but had engaged in good-faith communication with the claimant. *LaMantia* v. *Voluntary Plan Adm'rs, Inc.*, 401 F.3d 1114, 1122-1124 (2005).[4]

More recently, the Second Circuit held that the *de novo* standard should be applied in a case in which the administrator did not render a decision before the "deemed denied" deadline. *Nichols* v. *Prudential Ins. Co.*, 406 F.3d 98 (2005). In so doing, the Second Circuit specifically left open the question whether deferential review would be appropriate where there was substantial compliance with the regulatory deadline, as the Ninth and Tenth Circuits had suggested, because there was no substantial compliance in that case. *Id.* at 109-110.

While not expressly adopting a "substantial compliance" standard, the Eighth Circuit has taken a similarly context-

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[4] In *LaMantia*, the Ninth Circuit also relied on the fact that it was the claimant who sought an extension to file additional documents, which caused the decision to be rendered beyond the "deemed denied" deadline. 401 F.3d at 1123-1124. The court noted that, by allowing more information to be filed after the deadline and then rendering a decision on the merits, the administrator was exercising discretion under the plan. *Id.* at 1123. If an administrator's decision were subject to *de novo* review in those circumstances, the court explained, there would be no incentive for an administrator to allow extensions for the benefit of claimants. *Id.* at 1124. Because the "deemed denied" provision of the prior regulations was for the claimant's benefit, and because the standard of review in suits for benefits under Section 1132(a)(1)(B) derives from trust principles developed in equity, the Ninth Circuit appropriately attached significance to the claimant's role in causing the delay.

Petitioner contends (Pet. 16 n.7; Reply Br. 6) that the Ninth Circuit in the instant case "paid lip service to the Tenth Circuit's 'substantial compliance' approach" and "in reality" applied a uniform *de novo* standard of review. That assertion is incorrect and belied by the Ninth Circuit's subsequent decision in *LaMantia*. The question whether the Ninth Circuit correctly applied its context-dependent rule in the circumstances of this case does not warrant this Court's review.

dependent approach. In *McGarrah* v. *Hartford Life Insurance Co.*, 234 F.3d 1026 (8th Cir. 2000), the court held that the failure of an administrator to respond to a claimant's request for review was insufficient, by itself, to subject the administrator's initial decision to *de novo* review. *Id.* at 1031. Instead, the court reasoned, an administrator's decision would be subject to *de novo* review only if any procedural irregularity "raise[d] * * * 'serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim.'" *Ibid.* (quoting *Buttram* v. *Central States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996)). The court concluded that the claimant had failed to meet that standard because the administrator had made a thorough investigation and adequately explained the reasons for the termination of disability benefits in its initial decision, and because the claimant had presented no new medical evidence on appeal. *Ibid.* Applying the same standard, the Eighth Circuit subsequently reached the opposite result in a case in which the claimant had presented substantial new evidence on appeal, including reports from five doctors. *Seman* v. *FMC Corp. Retirement Plan for Hourly Employees*, 334 F.3d 728, 733 (8th Cir. 2003).[5]

Finally, the Third Circuit applied a *de novo* standard of review in *Gritzer* v. *CBS, Inc.*, 275 F.3d 291 (2002), where the plan administrator had not issued even an initial decision by the time the claimants had filed suit and did not do so until nearly five months later. See *id.* at 294-295. In those circumstances, the Third Circuit agreed with the claimants that

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[5] To the extent that the Eighth and Tenth Circuits have suggested that an administrator's *initial* decision for review may be entitled to deference when the claimant failed to provide new evidence or raise new issues at the appeal stage and the claim was deemed denied on appeal, that theory would not be available here, because petitioner's plan conferred discretion on the claims administrator only at the appeal stage and not at the initial stage. Compare Pet. App. 136a-139a (initial stage) with Pet. App. 139a-142a (appeal stage).

"there simply is no analysis or 'reasoning' to which the Court may defer under the arbitrary and capricious standard." *Id.* at 296 (internal quotation marks omitted). Applying the trust principles on which this Court relied in *Firestone Tire*, the Third Circuit reasoned that, "[w]here a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer." *Ibid.* The result reached by the Third Circuit in *Gritzer* is fully consistent with the decisions of the Ninth Circuit and the other circuits discussed above, and its decision does not appear to foreclose a deferential standard of review where there was substantial compliance with the regulatory deadlines.

b. Two circuits, the Fifth and Sixth, have applied a deferential standard of review, seemingly without qualification, to an administrator's initial decision where the administrator failed to issue a decision on appeal. The Sixth Circuit, however, addressed the issue 17 years ago, even before this Court's decision in *Firestone Tire*, in which the Court made clear that *de novo* review, not deferential review, is the default rule. *Daniel* v. *Eaton Corp.*, 839 F.2d 263, 267 (6th Cir.), cert. denied, 488 U.S. 826 (1988). Since *Firestone Tire*, the Sixth Circuit has recognized that "there is undeniable logic in the view that a plan administrator should forfeit deferential review by failing to exercise its discretion in a timely manner," but ultimately found it unnecessary to resolve that question in the case before it. *University Hospitals* v. *Emerson Elec. Co.*, 202 F.3d 839, 846 n.3 (6th Cir. 2000). As the court of appeals in this case observed (Pet. App. 13a), the issue thus appears to be open in the Sixth Circuit. At the very least, to the extent the Sixth Circuit's decision in *Daniel* retains force, the Sixth Circuit may well reconsider *Daniel* if confronted with the issue in the future, in light of this Court's intervening

decision in *Firestone Tire* and its own subsequent pronouncement in *University Hospitals*.

The Fifth Circuit, in a 1993 decision, held that a deferential standard of review was applicable to an administrator's factual determinations in a "deemed denied" case, stating that "the standard of review is no different whether the claim is actually denied or is deemed denied." *Southern Farm Bureau Life Ins. Co.* v. *Moore*, 993 F.2d 98, 101 (1993). As another court of appeals has noted, however, the Fifth Circuit "provided no explanation or authority for this statement." *Gilbertson*, 328 F.3d at 633. Because the Fifth Circuit's analysis in *Southern Farm Bureau* was so cursory, and because its decision in that case preceded all of the decisions from other circuits that have since provided for *de novo* review in appropriate circumstances, the Fifth Circuit may well revisit the issue, and elaborate on its analysis, if presented with the issue in another case. Indeed, the Fifth Circuit specifically noted in *Southern Farm Bureau* that the claimant in that case had presented no authority for *de novo* review, 993 F.2d at 101 n.6—a state of affairs that has now greatly changed.

c. In short, there is no clear and current conflict among the circuits warranting this Court's review on the standard-of-review issue presented here. To the contrary, in recent cases considering the issue, there is an emerging consensus that deferential review is appropriate under the Secretary's prior regulations where the administrator substantially complied with the applicable deadlines, but that *de novo* review is appropriate where it did not.

B. The Decision Below Is Correct

Consistent with the prevailing view in the cases just discussed, the court of appeals reasonably determined that *de*

novo review was appropriate in the particular circumstances of this case.[6]

1. Principles of trust law support the rule allowing *de novo* review in appropriate "deemed denied" cases. When ERISA itself and the Secretary's implementing regulations are silent, this Court has looked to trust-law principles in order to "develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" *Firestone Tire*, 489 U.S. at 110 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)). Applying those principles in *Firestone Tire*, this Court recognized a default rule that an administrator's decision to deny benefits under ERISA was reviewed *de novo*, but that more deferential review was warranted when the administrator was "exercis[ing] discretionary powers." *Id.* at 111.

When an ERISA administrator having discretion under the plan fails to issue a decision on review at all, or fails to comply substantially with the mandatory deadlines and the claim is therefore "deemed denied," the administrator has failed to act within the scope of the discretion conferred by the plan. That is so because the administrator's discretion is necessarily limited by the governing regulations as well as by the terms of the plan itself, which in this case incorporated the regulations' deadlines and "deemed denied" language. Pet. App. 140a-141a; 29 U.S.C. 1104(a)(1)(D), 1133; cf. Restatement (Second) of Trusts § 187 cmt. a (1959) ("The exercise of a power is discretionary except to the extent to which

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[6] Contrary to the assertions of both parties (Pet. 21 n.8; Br. in Opp. 9-11), the Department of Labor has not previously taken a position on the applicable standard of review in cases in which the claim for benefits was "deemed denied on review" under the prior regulations. The parties' assertions are based only on explanatory materials issued in connection with the new regulations, see Br. in Opp. 10, and on interpretive guidance on the Department's website concerning the discrete question of when exhaustion of plan remedies is required under the new regulations, see Pet. 21 n.8.

its exercise is required by the terms of the trust or by the principles of law applicable to the duties of trustees.").

It is, in fact, well established under the law of trusts that, "even where a trustee has discretion whether or not to make any payments to a particular beneficiary, the court will interpose if the trustee, arbitrarily or without knowledge of or inquiry into relevant circumstances, fails to exercise that discretion." Restatement (Third) of Trusts § 50 cmt. b (2003); accord Restatement (Second) of Trusts § 187 cmt. h (1959); 3 Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 187.3, at 40-44 (4th ed. 1988) (Scott & Fratcher). Under those circumstances, a court is free to take new evidence, make its own judgment about the benefits due, and order payment by the trustee or remand the matter to the trustee with instructions, as it sees fit. Restatement (Third), *supra*, § 50 cmt. b; 3 Scott & Fratcher § 187.1, at 27-32; *Colton* v. *Colton*, 127 U.S. 300, 322 (1898). Applying those principles in the ERISA context, if an administrator failed to comply substantially with mandatory deadlines under governing regulations and plan terms that deem a claim to be denied in the event of such a failure, the administrator has not acted within the scope of its discretion, and the default rule of *de novo* review is appropriate.

b. Application of the default rule in these circumstances creates an incentive for plan administrators to comply with the processing deadlines under the Secretary's regulations. Although the Secretary's earlier regulations governing review of claims for disability benefits did not purport to specify a standard of review for claims "deemed denied on review," they did make clear that the deadlines for the processing of benefit claims were mandatory. Thus, the regulations specified that the initial notice of denial "*shall* be furnished to the claimant within a reasonable period of time," not to exceed 180 days from the filing of the claim. 29 C.F.R. 2560.503-1(e)(1) and (3) (2000) (emphasis added). If notice of the denial

was not provided within that period, the claim "*shall* be deemed denied," and the claimant "*shall* be permitted to proceed" to the appeal stage. 29 C.F.R. 2560.503-1(e)(2) (2000) (emphases added). At the appeal stage, in turn, the regulations provided that a decision "*shall* be made promptly," and in no event more than 120 days from the filing of the request for review. 29 C.F.R. 2560.503-1(h)(1)(i) (2000) (emphasis added). Finally, if the fiduciary failed to furnish its decision to the claimant within that period, the claim "*shall* be deemed denied on review." 29 C.F.R. 2560.503-1(h)(4) (2000) (emphasis added).

In promulgating those provisions immediately after ERISA's enactment, the Secretary of Labor recognized that they were vital to the ERISA claims-resolution process. In fact, although those regulations as originally proposed contained time limits only for decisions on review, see 39 Fed. Reg. 42,243 (1974), the final regulations contained time limits for initial decisions as well, in response to comments that such time limits were necessary to "induce plans to process the initial claim promptly" and to "eliminate unreasonable delays in responding to claims," 42 Fed. Reg. 27,427 (1977). That interest in inducing plans to process claims promptly supports *de novo* review in appropriate cases in which the plan administrator failed substantially to comply with the mandatory deadlines.

c. In this case, the court of appeals reasonably concluded that, "while deference may be due to a plan administrator that is engaged in a good faith attempt to comply with its deadlines when they lapse, this is not such a case." Pet. App. 7a. After petitioner denied respondent's claim at the initial stage, respondent appealed and submitted new medical evidence to support his claim. *Id.* at 34a-35a. Petitioner failed to provide the required written notice that additional time was required within the initial 60-day period for review; failed to provide any form of written notice until one day before the expiration

of the extended 120-day period; and failed to specify, in that written notice, what additional information was required. Moreover, petitioner did not issue a decision until a year after the appeal was filed, ten months after it was "deemed denied" under the relevant regulation (and the express terms of the plan), and more than a month after respondent filed suit in federal district court. *Id.* at 5a-6a, 141a-142a. In those circumstances, *de novo* review was appropriate.

C. The Question Presented Is Of Limited And Diminishing Importance In Light Of Regulatory Changes

Finally, even if there were a sufficient circuit conflict on the appropriate standard of review in cases in which the underlying claim for benefits was "deemed denied on review" under the former regulations, and even if the decision below were erroneous in applying a *de novo* standard, further review would not be warranted because the Secretary of Labor has promulgated new regulations that abolish the regulatory concept of a deemed denial and may otherwise affect the standard-of-review issue.

1. In 2000, the Secretary replaced the former regulations governing claims procedures applicable here with comprehensive new regulations applicable to all claims filed on or after January 1, 2002. 29 C.F.R. 2560.503-1.[7] The new regulations differ in several material respects from those at issue in this case. Perhaps most important, the new regulations no longer provide that a claim will be "deemed denied on review" if the decision on review is not made within a specified period, 29 C.F.R. 2560.503-1(h)(4) (2000), and thus eliminate the "deemed denied" directive on which the Ninth Circuit and

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[7] For health-benefit claims, the effective date of the new regulation is no later than January 1, 2003. 29 C.F.R. 2560.503-1(o).

other courts specifically relied in declining to afford deference to an administrator's decision.[8]

Instead, the new regulations dispense with the exhaustion requirement and allow a claimant to proceed directly to federal court in the event of a broader range of procedural violations, including violations of newly adopted requirements contained elsewhere in the regulations. 29 C.F.R. 2560.503-1(*l*). Under the relevant provision, when a plan has failed to "establish or follow claims procedures consistent with the requirements of [the regulations]," a claimant is "deemed to have exhausted the administrative remedies available under the plan," and may file suit "on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." *Ibid.* That provision allows such a claimant to proceed directly to court without waiting for a denial of his claim, whether "deemed" or actual. If a claimant invokes that provision and the court agrees that the plan has failed to provide a reasonable claims procedure, the court might then conclude that the default rule of *de novo* consideration is triggered as a corollary. The appropriate manner of review in various scenarios that could arise under that provision should be determined in concrete cases as they are presented in the future.

Beyond the elimination of the "deemed denied" provision, the new regulations contain other features that may affect the appropriate standard of review. First, the regulations, while modestly shortening the time for deciding disability claims, 29

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[8] Petitioner contends (Reply Br. 3) that, even though the "deemed denied" provision has been deleted from the new regulations, "the question presented remains live" because some plans may retain the "deemed denied" language as a matter of plan design. In the absence of a "deemed denied" provision in governing regulations, however, the interpretation of language in a plan deeming a claim to be denied if plan deadlines are not met, and the consequences for failing to meet those deadlines, may present different considerations than in a case controlled by the former regulations.

C.F.R. 2560.503-1(f)(3) and (i)(3), contain new and more flexible tolling provisions that enable an administrator to extend the governing time limits in cases in which the administrator requires additional information from the claimant, 29 C.F.R. 2560.503-1(f)(4) and (i)(4). Those provisions were specifically intended to "provide plans with the flexibility necessary to handle all claims appropriately, whether such claims are easy or difficult, complete when filed or needing more information." 65 Fed. Reg. 70,250 (2000). The availability of those tolling provisions addresses petitioner's concern (Pet. 22-24) that a rule under which noncompliance with rigid deadlines automatically triggers *de novo* review would penalize the plan if its administrator needed (or if the claimant wanted to submit) additional information. See, *e.g.*, Pet. App. 29a (Tashima, J., dissenting); *Gilbertson*, 328 F.3d at 634-635.[9]

Second, the new regulations provide more detailed procedural requirements for an administrator's review of an initial denial of a disability claim. The regulations specify that plan decisions on review (1) may not "afford deference to the initial adverse benefit determination," 29 C.F.R. 2560.503-1(h)(3)(ii) and (h)(4); (2) must be made by a fiduciary who is "neither the individual who made the adverse benefit determination [initially], nor the subordinate of such individual," 29 C.F.R. 2560.503-1(h)(3)(ii) and (h)(4); and (3) must, in a case requiring a medical judgment, include consultation with a health care professional who has "appropriate training and experience in the field of medicine involved in the medical judgment" and who was not consulted in connection with the initial decision, 29 C.F.R. 2560.503-1(h)(3)(iii), (h)(3)(v), and (h)(4).

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[9] The increased flexibility built into the regulations may also cause courts to refine the extent to which a rule of substantial compliance designed to accommodate situations involving "an ongoing, good faith exchange of information between the administrator and the claimant," *Gilbertson*, 328 F.3d at 631, is necessary to ameliorate the consequences of an absolute rule of *de novo* review in the face of noncompliance with the regulatory deadlines.

Those provisions were designed to increase the independence and integrity of the appeal process. 65 Fed. Reg. at 70,252-70,253. Those new requirements attach enhanced significance to appeals, and may affect the propriety of judicial deference to a plan's *initial* decision on the theory that the claimant was not prejudiced by the absence of a full and fair review on appeal. See, *e.g.*, *Finley*, 379 F.3d at 1175; *McGarrah*, 234 F.3d at 1031.[10]

2. Because the analysis under the new regulations may well differ from the analysis under the regulations applicable to this case, a decision in this case would affect only the shrinking number of extant claims filed before the effective date of the new regulations—January 1, 2002, or, for health-benefit claims, January 1, 2003. According to Department of Labor estimates published in conjunction with the new regulations, approximately 1.4 million disability claims were filed annually as of 2000. 65 Fed. Reg. at 70,263. Only approximately 25,000 of those claims were denied (much less "deemed denied") on review, and the great majority of those claimants presumably did not seek judicial review. *Ibid.*[11] Moreover, although ERISA specifies no uniform limitations period for judicial review of benefit claims under 29 U.S.C. 1132(a)(1)(B), judicial review with respect to disability claims filed before

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[10] No court of appeals, including the Fifth or Sixth Circuit (see pp. 11-12, *supra*), has yet addressed the appropriate standard of review in cases arising under the new regulations, although at least one court of appeals has specifically reserved the question. See *Finley*, 379 F.3d at 1175 n.6. Because this case arises under the prior regulations, it would not be an appropriate vehicle to consider that question.

[11] Petitioner errs in suggesting (Pet. 10, 23) that the Department of Labor has estimated that 14 million decisions annually are not made within the prescribed time limits. The figure petitioner cites refers not to disability claims, but instead only to health-benefit claims, and specifically to the number of health-benefit claims whose adjudication would have had to be accelerated to comply with the time limits in the new regulations. 65 Fed. Reg. at 70,257.

January 1, 2002, is as a practical matter likely to be substantially complete in the near future. The question of the appropriate standard of judicial review of benefit claims that were "deemed denied" under the prior regulations therefore is of limited and diminishing importance. For that reason, as well as the reasons given in Points A and B above, this case does not warrant the Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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